UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO

WESTERN DIVISION

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| ERIC L. JEFFRIES, Plaintiff, vs. CENTRE LIFE INSURANCE COMPANY, et al., Defendants. | : | Case No. C-1-02-351 (Volume I) |

Deposition of MICHAEL MCCLELLAN, MD, a witness herein, called by the defendants for cross-examination, pursuant to the Federal Rules of Civil Procedure, taken before me, Connie Dupps, a Registered Professional Reporter and Notary Public in and for the State of Ohio, at the offices of Hyde Park Internists, 2727 Madison Road, Cincinnati, Ohio, on Tuesday, October 14, 2003, at 3:00 PM.

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A. Okay.

Q. All right. Doctor, last night your office was kind enough to give me a copy of your records in the case of Eric Jeffries. Do you recall Mr. Jeffries as a patient?

A. I do.

Q. Can you tell me from your records, which I assume you have with you, when the first time you saw him would have been?

A. Actually I first saw Eric 5 years ago to the day today, October 14, 1998.

Q. What was the occasion of that visit, what brought him to you?

A. Mr. Jeffries had been under the primary care of Dr. Donald Nunlist-Young, and at that time was also under the care of several other specialists being evaluated for an, as yet undefined, illness, and he felt that he wanted another primary care opinion from a generalist. He had seen a few different specialists, but wanted someone other than Dr. Nunlist-Young to examine him and give another opinion on his illness.

Q. Okay. When you first saw him I assume you made a record of the history that he gave you?

A. The list of potential diagnoses was very broad and it included everything from infections; those would be, for example, mononucleosis, Ebstein bar virus infection, cytomegalovirus, herpes virus infections, as well as infections caused by, what we call, vectors, mosquito bite born, arthropod born infections, for example, Lyme disease.

They include many rheumatologic diseases, autoimmune disorders, lupus, rheumatoid arthritis, Behcet's disease, B E H C E T apostrophe S, as well as fibromyalgia, a nonautoimmune rheumatologic disorder, endocrinologic disorders, thyroid disease.

And there are other potential causes that we eventually looked into that include some very rare disorders, but I think at the time I originally saw him those were the initial primary considerations that had been looked at at that point.

Q. Over the course of time were you able to narrow the list?

A. We were able to exclude many of the disorders that we considered. We also went on to look into various gastrointestinal problems because he had abdominal pains as part of his symptom

complex, so we considered inflammatory bowel diseases, other infectious and noninfectious problems of the bowel, some very strange disorders, porphyrias, Whipple's disease, paroxysmal nocturnal hemoglobinuria, some diseases that I've only read about in textbooks and in 15 years in practice never seen a case of.

So we really did an extensive evaluation over the course of the next couple of years that I was caring for Eric to try to exclude every possible organic etiology that we could for his symptoms.

Q. Are you still caring for Mr. Jeffries at this time?

A. Yes.

Q. Did you do a physical examination on your first visit?

A. Yes.

Q. Was it essentially a normal exam?

A. Other than some mild tenderness in his right upper quadrant that I could elicit, everything else was normal.

Q. Were you advised of, in his medical history, that he had bouts of difficulties with his right upper quadrant or pain in his right upper

quadrant that predated the hepatitis injections?

A. I don't believe that I was aware of that as a predating condition.

Q. Are you aware of it today that it was a predating condition?

A. I have notes from my initial evaluation that he has -- that he had an evaluation of his right upper quadrant pain, including an ultrasound of his gallbladder and liver, but I was not then, and I don't believe I'm aware now, that that was a condition that existed before his immunizations.

Q. Okay. So you have seen no records from him going back into the '93, '94, '95, '96 era?

A. No. My review of his records were based on the time of his illness since he became acutely symptomatic.

Q. Coming forward?

A. (Nodding head.)

Q. It would be of interest to you, however, as a diagnostician to know whether or not he had been treated for right upper quadrant pain or epigastric pain prior to his injection, correct?

A. Correct.

Q. That would be significant history given

it's an ongoing symptom?

MR. ROBERTS: Objection.

A. It would be important to know the dating of that symptom.

Q. Were you advised that prior to -- we use the injection as the event date since that is his contention, correct, that this all -- all of the -- all of the problems that he's having stemmed from this injection, correct?

MR. ROBERTS: Objection.

A. Right.

Q. So if we use that as the date of the event, were you advised that prior to the event he had been diagnosed and treated for the herpes virus?

MR. ROBERTS: Objection. Go ahead.

A. Can you say that again, please.

Q. Yes. Prior to the event date were you made aware that he had been treated for the herpes virus or for a herpes infection?

A. So your question is was I aware --

Q. That he had a history that predated the event.

A. -- at that time or now that he was being treated for herpes previous to?

those symptoms have been unabated despite the attempts of treatment.

I think one could argue that his lack of response to anti-inflammatory medications may mean that this is not an overtly inflammatory disorder. It doesn't mean that it's still not a real direct and causal relationship to the vaccine though.

Q. Put aside the cause, which is of little or no importance to me, I'm trying to figure out what's wrong with Mr. Jeffries, as you have been for a number of years. I understood you to tell me that you believe that you know what's wrong with him, and that's what I want you to describe to me, what body system is being affected and why?

A. I believe it stems primarily from a central nervous system problem. Although, the nervous system also involves the gut and so it's quite conceivable to me that his abdominal symptoms relate to nervous system involvement of the innervation of his visceral organs in the abdomen.

I believe that his persisting muscle pains, his persisting cognitive problems, his persisting weakness, predominantly favoring his right side relate to some sort of an immune-mediated

make a diagnosis, to give a definitive diagnosis, or to exclude one.

Q. Okay. In this case we know we have the patient's history as one of the tools that would go into your reasoning to what is wrong with this particular patient, that's the given, right?

A. That's very important.

Q. All right. Your clinical exams, as I read them, and I could be wrong on this because I only got them last night in their entirety, but the clinical exams by and large were negative in their findings, correct?

A. More recently, going from my memory, I would say within the last year or 18 months Eric has exhibited some mild right-sided weakness, decreased arm swing with his gait on the right side, and so that is, I think, a significant finding. It's not a normal finding. Other --

Q. How did you measure -- I'm sorry.

A. Other than that, the remainder of his physical exam findings have been very unremarkable.

Q. How did you measure the decreased strength on the right side?

A. By resistance muscle testing, asking him

A. He certainly has.
Q. And desired to explore them to the nth degree?
A. He has been very active in his own care and his own case management, yes.
Q. In fact, he's been the most active patient you've ever had?
A. That would be a fair statement.
Q. When he comes in with his history, I'm assuming that you take the history at face value?
A. Don't know what history you would be specifically referring to.
Q. Whatever history he --
A. Anything that he comes in and might mention to me, I always -- I always listen.
Q. All right. Let me make it more concrete. If he comes in and tells you I took the boys to Florida last week and it wiped me out for four days, that would be the kind of history you would take, accept at face value, and go on, right?
A. Yes.
Q. That he's having difficulty cognitively, something you take at face value and go on?
A. For the most part, yes.

A. It was one of the ones that were considered, but were determined that he did not have fibromyalgia, yes.

Q. So now we're talking about as of yet an unidentified disease process, at least as far as medical literature is concerned, that is affecting Mr. Jeffries?

A. Well, other than the case reports in the literature, which you have seen the reports from some of the other specialists who have made note of a series of patients that they have seen with similar illnesses. It does not yet carry a specific diagnostic label in the medical literature.

Q. When you say other experts in the field, are we talking about Dr. Hyde in large part?

A. Well, mostly talking about Dr. Weisbraun, I believe --

Q. Dr. Weisman?

A. -- who saw the patient.

Q. Let me ask you a question about those two while we have them on the table. Do you know either Dr. Hyde or Dr. Weisman?

A. I do not.

Q. Do you know whether or not they earn their

his symptoms, that's a rare process, but I'm not sure that it's atypical for that process.

Q. How many patients like Mr. Jeffries do you have, Doctor?

A. I don't have any others, thank the Lord for that.

Q. How many patients do you have that have gone to the extent of using their own funds to fly to England, Brussels, Ottawa, Milwaukee, California, Oklahoma, Alabama, Massachusetts, Florida, all for purposes of seeking a diagnosis?

A. None. And also say that none of the other patients that I have who I do treat for obsessive compulsive disorder, and who I see with somatization disorder are ever that persistent or that willing to go to that extent, or to risk potential loss of his diagnosis that we have taken so much pains to go to to try to narrow the scope of, by going back out on another limb to chase down another possibility.

Only ones who really are interested I would suggest -- I would say that that strikes me as someone who really wants to be well, not someone who wants to continue to focus on his symptoms, which people with somatization disorder prefer to do.

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Deposition of MICHAEL MCCLELLAN, MD, a witness herein, called by the defendants for cross-examination, pursuant to the Federal Rules of Civil Procedure, taken before me, Connie Dupps, a Registered Professional Reporter and Notary Public in and for the State of Ohio, at the offices of Hyde Park Internists, 2727 Madison Road, Cincinnati, Ohio, on Tuesday, October 28, 2003, at 4:20 PM.

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or the other on the evaluation of Mr. Jeffries?

MR. ROBERTS: Objection.

A. To my knowledge, again I'm not an expert in this area, but the finding of IgA nephropathy in a first degree relative would not impact Mr. Jeffries -- the evaluation of Mr. Jeffries' medical condition. It would not lead me in a direction to look for other possibilities in him.

Q. September 10th, 2002 you've got a report from the University of Chicago, Department of Neurology from a Dr. Roos?

A. Yes.

Q. Dr. Roos's examination was completely negative; is that correct?

MR. ROBERTS: Objection.

A. Other than decreased arm swing on one side, he doesn't note which side.

Q. In the assessment -- now that I've dropped it I may never find it again.

A. I can give you my copy.

Q. I've got it. In the assessment the doctor found that the episodes of paresthesia, weakness, pain, mental cloudiness are in contrast to the patient's neurologic -- normal neurologic exam?

was functional movement disorder, correct?

A. That's what he suggests in his impression.

Q. And a functional movement disorder is in effect a psychogenic problem, is it not?

MR. ROBERTS: Objection.

A. To tell you the truth I've never seen that exact wording before and I don't know what he means by that.

Q. Okay. Let's look at his last paragraph. He says I explained to the patient that this was good news, that most of the other symptoms -- or syndromes listed above are progressive neurologic disorders for which we don't have a cure, and only partially satisfactory symptomatic treatment.

In contrast a functional movement disorder has potential to have complete recovery provided the patient follows through with a psychiatrist for long-term therapy, correct?

A. That's what he says.

Q. To cut to the chase, we're looking at probably the most examined patient I've ever seen and I think you said the most examined patient you've ever seen, and there is no objectively verifiable or repeatable tests or examination that

can establish a known physical ailment other than one by exclusion; is that correct?

MR. ROBERTS: Objection.

A. I would say that's correct, that there is no way to definitively make the diagnosis other than through exclusion.

Q. And to make a diagnosis by exclusion one has to eliminate or rule out other potential diagnoses or causes for the symptoms that are being expressed by the patient?

MR. ROBERTS: Objection.

Q. Correct?

A. Correct.

Q. And if objective testing of a neuropsychological nature strongly suggests a diagnosis of somatoform disorder and obsessive traits --

MR. ROBERTS: Somatization disorder?

Q. -- or obsession with the illness, that means that's one potential that has not been ruled out?

MR. ROBERTS: Objection.

A. Well, unfortunately, as we talked about last time, neuropsychiatric testing is not, in and

of itself, diagnostic either, and I would say that a functional movement disorder, Dr. Dalvi says is his --

Q. Explanation?

A. -- presumptive diagnosis is, in and of itself, a diagnosis of exclusion for which there is no verifiable testing or diagnostic tests, which would be confirmative.

Q. But as with your diagnosis it does explain the symptoms and provide a potential treatment to help the patient get over them, right?

MR. ROBERTS: Objection.

A. It is another, certainly, another potential explanation for his symptoms. And I think what it comes down to for me, a lot of these folks that saw Mr. Jeffries once will be able to give a very helpful objective evaluation of someone for whom they have no background, whom they have not had longitudinal history with, and that's many times a very good thing, to get a fresh look and to think of new ideas and new possibilities, because your -- your way of seeing a patient is not clouded by previous encounters with them.

On the other hand, I think that it betrays